TennCare Companion Guide

837 Health Care Claim : Institutional
V5010X223A2

Version: 1.0 Final

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Company:	**Bureau of TennCare**
Publication:	**11/19/2011**
Trading Partner:	**Encounter Partner**
Notes:	

Introduction/ Purpose:

TennCare Companion Guides (TCCGs) are intended to supplement the ASC X12N Standards for Electronic Data Interchange, Technical Report Type 3 (TR3), for each HIPAA transaction set. The rules for transaction formats/structures and data contents including field values can be found in the TR3 guides. TCCGs provide specific information on the fields and values required for transactions sent to or received from TennCare.

TCCGs are intended to be supplemental to and NOT a replacement for, the standard ASC X12N TR3 guide for each transaction set. Based upon reporting circumstances, certain loops or data elements that are normally situational may become required. Some of these situational loops may not be included within the TCCG for a given transaction; however, requirements within TR3s must be followed when using different loops, segments and data elements. HIPAA required information must be met even if it's not part of the TCCG.

Other than transaction formats and data contents, please refer to TCCGs Front Matter (Version 5010) for Trading Partner arrangements with TennCare.

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Functional Group=HC

Purpose: This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Not Defined:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
	ISA	Interchange Control Header	M	1			Required
	GS	Functional Group Header	M	1			Required

Heading:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
0050	ST	Transaction Set Header	M	1			Required
0100	BHT	Beginning of Hierarchical Transaction	M	1			Required
LOOP ID - 1000A					1	N1/0200L	
0200	NM1	Submitter Name	O	1		N1/0200	Required
0450	PER	Submitter EDI Contact Information	O	2			Required
LOOP ID - 1000B					1	N1/0200L	
0200	NM1	Receiver Name	O	1		N1/0200	Required

Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
LOOP ID - 2000A					>1		
0010	HL	Billing Provider Hierarchical Level	M	1			Required
0030	PRV	Billing Provider Specialty Information	O	1			Situational
0100	CUR	Foreign Currency Information	O	1			Situational
LOOP ID - 2010AA					1	N2/0150L	
0150	NM1	Billing Provider Name	O	1		N2/0150	Required
0250	N3	Billing Provider Address	O	1			Required
0300	N4	Billing Provider City, State, ZIP Code	O	1			Required
0350	REF	Billing Provider Tax Identification	O	1			Required
0400	PER	Billing Provider Contact Information	O	2			Situational
LOOP ID - 2010AB					1	N2/0150L	
0150	NM1	Pay-to Address Name	O	1		N2/0150	Situational

0250	N3	Pay-To Address - ADDRESS	O	1			Required
0300	N4	Pay-to Address City, State, ZIP Code	O	1			Required
LOOP ID - 2010AC					**1**	**N2/0150L**	
0150	NM1	Pay-To Plan Name	O	1		N2/0150	Situational
0250	N3	Pay-To Plan Address	O	1			Required
0300	N4	Pay-To Plan City/State/Zip Code	O	1			Required
0350	REF	Pay-To Plan Secondary Identification	O	1			Situational
0350	REF	Pay-To Tax Identification Number	O	1			Required
LOOP ID - 2000B					**>1**		
0010	HL	Subscriber Hierarchical Level	M	1			Required
0050	SBR	Subscriber Information	O	1			Required
LOOP ID - 2010BA					**1**	**N2/0150L**	
0150	NM1	Subscriber Name	O	1		N2/0150	Required
0250	N3	Subscriber Address	O	1			Situational
0300	N4	Subscriber City, State, ZIP Code	O	1			Situational
0320	DMG	Subscriber Demographic Information	O	1			Situational
0350	REF	Subscriber Secondary Identification	O	1			Situational
0350	REF	Property and Casualty Claim Number	O	1			Situational
LOOP ID - 2010BB					**1**	**N2/0150L**	
0150	NM1	Payer Name	O	1		N2/0150	Required
0250	N3	Payer Address	O	1			Situational
0300	N4	Payer City, State, ZIP Code	O	1			Situational
0350	REF	Payer Secondary Identification	O	3			Situational
0350	REF	Billing Provider Secondary Identification	O	1			Situational
LOOP ID - 2300					**100**		
1300	CLM	Claim information	O	1			Situational
1350	DTP	Discharge Hour	O	1			Situational
1350	DTP	Statement Dates	O	1			Required
1350	DTP	Admission Date/Hour	O	1			Situational
1350	DTP	Date - Repricer Received Date	O	1			Situational
1400	CL1	Institutional Claim Code	O	1			Required
1550	PWK	Claim Supplemental Information	O	10			Situational
1600	CN1	Contract Information	O	1			Situational
1750	AMT	Patient Estimated Amount Due	O	1			Situational
1800	REF	Service Authorization Exception Code	O	1			Situational
1800	REF	Referral Number	O	1			Situational
1800	REF	Prior Authorization	O	1			Situational
1800	REF	Payer Claim Control Number	O	1			Situational
1800	REF	Repriced Claim Number	O	1			Situational
1800	REF	Adjusted Repriced Claim Number	O	1			Situational
1800	REF	Investigational Device Exemption Number	O	5			Situational

1800	REF	Claim Identifier For Transmission Intermediaries	O	1			Situational
1800	REF	Auto Accident State	O	1			Situational
1800	REF	Medical Record Number	O	1			Situational
1800	REF	Demonstration Project Identifier	O	1			Situational
1800	REF	Peer Review Organization (PRO) Approval Number	O	1			Situational
1850	K3	File Information	O	10			Situational
1900	NTE	Claim Note	O	10			Situational
1900	NTE	Billing Note	O	1			Situational
2200	CRC	EPSDT Referral	O	1			Situational
2310	HI	Principal Diagnosis	O	1			Required
2310	HI	Admitting Diagnosis	O	1			Situational
2310	HI	Patient's Reason For Visit	O	1			Situational
2310	HI	External Cause of Injury	O	1			Situational
2310	HI	Diagnosis Related Group (DRG) Information	O	1			Situational
2310	HI	Other Diagnosis Information	O	2			Situational
2310	HI	Principal Procedure Information	O	1			Situational
2310	HI	Other Procedure Information	O	2			Situational
2310	HI	Occurrence Span Information	O	2			Situational
2310	HI	Occurrence Information	O	2			Situational
2310	HI	Value Information	O	2			Situational
2310	HI	Condition Information	O	2			Situational
2310	HI	Treatment Code Information	O	2			Situational
2410	HCP	Claim Pricing/Repricing Information	O	1			Situational
LOOP ID - 2310A					**1**	**N2/2500L**	
2500	NM1	Attending Provider Name	O	1		N2/2500	Situational
2550	PRV	Attending Provider Specialty Information	O	1			Situational
2710	REF	Attending Provider Secondary Identification	O	4			Situational
LOOP ID - 2310B					**1**	**N2/2500L**	
2500	NM1	Operating Physician Name	O	1		N2/2500	Situational
2710	REF	Operating Physician Secondary Identification	O	4			Situational
LOOP ID - 2310C					**1**	**N2/2500L**	
2500	NM1	Other Operating Physician Name	O	1		N2/2500	Situational
2710	REF	Other Operating Physician Secondary Identification	O	4			Situational
LOOP ID - 2310D					**1**	**N2/2500L**	
2500	NM1	Rendering Provider Name	O	1		N2/2500	Situational
2710	REF	Rendering Provider Secondary Identification	O	4			Situational
LOOP ID - 2310E					**1**	**N2/2500L**	
2500	NM1	Service Facility Location Name	O	1		N2/2500	Situational
2650	N3	Service Facility Location Address	O	1			Required
2700	N4	Service Facility Location	O	1			Required

		City/State/ZIP					
2710	REF	Service Facility Secondary Identification	O	3			Situational
LOOP ID - 2310F					**1**	**N2/2500L**	
2500	NM1	Referring Provider Name	O	1		N2/2500	Situational
2710	REF	Referring Provider Secondary Identification	O	3			Situational
LOOP ID - 2320					**10**	**N2/2900L**	
2900	SBR	Other Subscriber Information	O	1		N2/2900	Situational
2950	CAS	Claim Level Adjustments	O	5			Situational
3000	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	1			Situational
3000	AMT	Remaining Patient Liability	O	1			Situational
3000	AMT	Coordination of Benefits (COB) Total Non-covered Amount	O	1			Situational
3100	OI	Other Insurance Coverage Information	O	1			Required
3150	MIA	Inpatient Adjudication Information	O	1			Situational
3200	MOA	Outpatient Adjudication Information	O	1			Situational
LOOP ID - 2330A					**1**	**N2/3250L**	
3250	NM1	Other Subscriber Name	O	1		N2/3250	Required
3320	N3	Other Subscriber Address	O	1			Situational
3400	N4	Other Subscriber City/State/ZIP Code	O	1			Situational
3550	REF	Other Subscriber Secondary Information	O	2			Situational
LOOP ID - 2330B					**1**	**N2/3250L**	
3250	NM1	Other Payer Name	O	1		N2/3250	Required
3320	N3	Other Payer Address	O	1			Situational
3400	N4	Other Payer City/State/ZIP Code	O	1			Situational
3500	DTP	Claim Check Or Remittance Date	O	1			Situational
3550	REF	Other Payer Secondary Identifier	O	2			Situational
3550	REF	Other Payer Prior Authorization Number	O	1			Situational
3550	REF	Other Payer Referral Number	O	1			Situational
3550	REF	Other Payer Claim Adjustment Indicator	O	1			Situational
3550	REF	Other Payer Claim Control Number	O	1			Situational
LOOP ID - 2330C					**1**	**N2/3250L**	
3250	NM1	Other Payer Attending Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Attending Provider Secondary Identification	O	4			Required
LOOP ID - 2330D					**1**	**N2/3250L**	
3250	NM1	Other Payer Operating Physician	O	1		N2/3250	Situational

3550	REF	Other Payer Operating Physician Secondary Identification	O	4			Required
LOOP ID - 2330E					**1**	**N2/3250L**	
3250	NM1	Other Payer Other Operating Physician	O	1		N2/3250	Situational
3550	REF	Other Payer Other Operating Physician Secondary Identification	O	4			Required
LOOP ID - 2330F					**1**	**N2/3250L**	
3250	NM1	Other Payer Service Facility Location	O	1		N2/3250	Situational
3550	REF	Other Payer Service Facility Location Secondary Identification	O	3			Required
LOOP ID - 2330G					**1**	**N2/3250L**	
3250	NM1	Other Payer Rendering Provider Name	O	1		N2/3250	Situational
3550	REF	Other Payer Rendering Provider Secondary Identifier	O	4			Required
LOOP ID - 2330H					**1**	**N2/3250L**	
3250	NM1	Other Payer Referring Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Referring Provider Secondary Identification	O	3			Required
LOOP ID - 2330I					**1**	**N2/3250L**	
3250	NM1	Other Payer Billing Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Billing Provider Secondary Identifier	O	2			Required
LOOP ID - 2400					**999**	**N2/3650L**	
3650	LX	Service Line Number	O	1		N2/3650	Required
3750	SV2	Institutional Service Line	O	1			Required
4200	PWK	Line Supplemental Information	O	10			Situational
4550	DTP	Date - Service Date	O	1			Situational
4700	REF	Line Item Control Number	O	1			Situational
4700	REF	Repriced Line Item Reference Number	O	1			Situational
4700	REF	Adjusted Repriced Line Item Reference Number	O	1			Situational
4750	AMT	Service Tax Amount	O	1			Situational
4750	AMT	Facility Tax Amount	O	1			Situational
4850	NTE	Third Party Organization Notes	O	1			Situational
4920	HCP	Line Pricing/Repricing Information	O	1			Situational
LOOP ID - 2410					**1**	**N2/4930L**	
4930	LIN	Drug Identification	O	1		N2/4930	Situational
4940	CTP	Drug Quantity	O	1			Required
4950	REF	Prescription or Compound Drug Association Number	O	1			Situational
LOOP ID - 2420A					**1**	**N2/5000L**	

5000	NM1	Operating Physician Name	O	1		N2/5000	Situational
5250	REF	Operating Physician Secondary Identification	O	20			Situational
LOOP ID - 2420B					**1**	**N2/5000L**	
5000	NM1	Other Operating Physician Name	O	1		N2/5000	Situational
5250	REF	Other Operating Physician Secondary Identification	O	20			Situational
LOOP ID - 2420C					**1**	**N2/5000L**	
5000	NM1	Rendering Provider Name	O	1		N2/5000	Situational
5250	REF	Rendering Provider Secondary Identification	O	20			Situational
LOOP ID - 2420D					**1**	**N2/5000L**	
5000	NM1	Referring Provider Name	O	1		N2/5000	Situational
5250	REF	Referring Provider Secondary Identification	O	20			Situational
LOOP ID - 2430					**15**	**N2/5400L**	
5400	SVD	Line Adjudication Information	O	1		N2/5400	Situational
5450	CAS	Line Adjustment	O	5			Situational
5500	DTP	Line Check or Remittance Date	O	1			Required
5505	AMT	Remaining Patient Liability	O	1			Situational
LOOP ID - 2000C					**>1**		
0010	HL	Patient Hierarchical Level	O	1			Situational
0070	PAT	Patient Information	O	1			Required
LOOP ID - 2010CA					**1**	**N2/0150L**	
0150	NM1	Patient Name	O	1		N2/0150	Required
0250	N3	Patient Address	O	1			Required
0300	N4	Patient City/State/ZIP Code	O	1			Required
0320	DMG	Patient Demographic Information	O	1			Required
0350	REF	Property and Casualty Claim Number	O	1			Situational
0350	REF	Property and Casualty Patient Identifier	O	1			Situational
LOOP ID - 2300					**100**		
1300	CLM	Claim information	O	1			Required
1350	DTP	Discharge Hour	O	1			Situational
1350	DTP	Statement Dates	O	1			Required
1350	DTP	Admission Date/Hour	O	1			Situational
1350	DTP	Date - Repricer Received Date	O	1			Situational
1400	CL1	Institutional Claim Code	O	1			Required
1550	PWK	Claim Supplemental Information	O	10			Situational
1600	CN1	Contract Information	O	1			Situational
1750	AMT	Patient Estimated Amount Due	O	1			Situational
1800	REF	Service Authorization Exception Code	O	1			Situational
1800	REF	Referral Number	O	1			Situational
1800	REF	Prior Authorization	O	1			Situational
1800	REF	Payer Claim Control Number	O	1			Situational
1800	REF	Repriced Claim Number	O	1			Situational

1800	REF	Adjusted Repriced Claim Number	O	1			Situational
1800	REF	Investigational Device Exemption Number	O	5			Situational
1800	REF	Claim Identifier For Transmission Intermediaries	O	1			Situational
1800	REF	Auto Accident State	O	1			Situational
1800	REF	Medical Record Number	O	1			Situational
1800	REF	Demonstration Project Identifier	O	1			Situational
1800	REF	Peer Review Organization (PRO) Approval Number	O	1			Situational
1850	K3	File Information	O	10			Situational
1900	NTE	Claim Note	O	10			Situational
1900	NTE	Billing Note	O	1			Situational
2200	CRC	EPSDT Referral	O	1			Situational
2310	HI	Principal Diagnosis	O	1			Required
2310	HI	Admitting Diagnosis	O	1			Situational
2310	HI	Patient's Reason For Visit	O	1			Situational
2310	HI	External Cause of Injury	O	1			Situational
2310	HI	Diagnosis Related Group (DRG) Information	O	1			Situational
2310	HI	Other Diagnosis Information	O	2			Situational
2310	HI	Principal Procedure Information	O	1			Situational
2310	HI	Other Procedure Information	O	2			Situational
2310	HI	Occurrence Span Information	O	2			Situational
2310	HI	Occurrence Information	O	2			Situational
2310	HI	Value Information	O	2			Situational
2310	HI	Condition Information	O	2			Situational
2310	HI	Treatment Code Information	O	2			Situational
2410	HCP	Claim Pricing/Repricing Information	O	1			Situational
LOOP ID - 2310A					**1**	**N2/2500L**	
2500	NM1	Attending Provider Name	O	1		N2/2500	Situational
2550	PRV	Attending Provider Specialty Information	O	1			Situational
2710	REF	Attending Provider Secondary Identification	O	4			Situational
LOOP ID - 2310B					**1**	**N2/2500L**	
2500	NM1	Operating Physician Name	O	1		N2/2500	Situational
2710	REF	Operating Physician Secondary Identification	O	4			Situational
LOOP ID - 2310C					**1**	**N2/2500L**	
2500	NM1	Other Operating Physician Name	O	1		N2/2500	Situational
2710	REF	Other Operating Physician Secondary Identification	O	4			Situational
LOOP ID - 2310D					**1**	**N2/2500L**	
2500	NM1	Rendering Provider Name	O	1		N2/2500	Situational
2710	REF	Rendering Provider Secondary Identification	O	4			Situational
LOOP ID - 2310E					**1**	**N2/2500L**	
2500	NM1	Service Facility Location	O	1		N2/2500	Situational

		Name					
2650	N3	Service Facility Location Address	O	1			Required
2700	N4	Service Facility Location City/State/ZIP	O	1			Required
2710	REF	Service Facility Secondary Identification	O	3			Situational
LOOP ID - 2310F					**1**	**N2/2500L**	
2500	NM1	Referring Provider Name	O	1		N2/2500	Situational
2710	REF	Referring Provider Secondary Identification	O	3			Situational
LOOP ID - 2320					**10**	**N2/2900L**	
2900	SBR	Other Subscriber Information	O	1		N2/2900	Situational
2950	CAS	Claim Level Adjustments	O	5			Situational
3000	AMT	Coordination of Benefits (COB) Payer Paid Amount	O	1			Situational
3000	AMT	Remaining Patient Liability	O	1			Situational
3000	AMT	Coordination of Benefits (COB) Total Non-covered Amount	O	1			Situational
3100	OI	Other Insurance Coverage Information	O	1			Required
3150	MIA	Inpatient Adjudication Information	O	1			Situational
3200	MOA	Outpatient Adjudication Information	O	1			Situational
LOOP ID - 2330A					**1**	**N2/3250L**	
3250	NM1	Other Subscriber Name	O	1		N2/3250	Required
3320	N3	Other Subscriber Address	O	1			Situational
3400	N4	Other Subscriber City/State/ZIP Code	O	1			Situational
3550	REF	Other Subscriber Secondary Information	O	2			Situational
LOOP ID - 2330B					**1**	**N2/3250L**	
3250	NM1	Other Payer Name	O	1		N2/3250	Required
3320	N3	Other Payer Address	O	1			Situational
3400	N4	Other Payer City/State/ZIP Code	O	1			Situational
3500	DTP	Claim Check Or Remittance Date	O	1			Situational
3550	REF	Other Payer Secondary Identifier	O	2			Situational
3550	REF	Other Payer Prior Authorization Number	O	1			Situational
3550	REF	Other Payer Referral Number	O	1			Situational
3550	REF	Other Payer Claim Adjustment Indicator	O	1			Situational
3550	REF	Other Payer Claim Control Number	O	1			Situational
LOOP ID - 2330C					**1**	**N2/3250L**	
3250	NM1	Other Payer Attending Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Attending Provider Secondary Identification	O	4			Required

LOOP ID - 2330D					**1**	**N2/3250L**	
3250	NM1	Other Payer Operating Physician	O	1		N2/3250	Situational
3550	REF	Other Payer Operating Physician Secondary Identification	O	4			Required
LOOP ID - 2330E					**1**	**N2/3250L**	
3250	NM1	Other Payer Other Operating Physician	O	1		N2/3250	Situational
3550	REF	Other Payer Other Operating Physician Secondary Identification	O	4			Required
LOOP ID - 2330F					**1**	**N2/3250L**	
3250	NM1	Other Payer Service Facility Location	O	1		N2/3250	Situational
3550	REF	Other Payer Service Facility Location Secondary Identification	O	3			Required
LOOP ID - 2330G					**1**	**N2/3250L**	
3250	NM1	Other Payer Rendering Provider Name	O	1		N2/3250	Situational
3550	REF	Other Payer Rendering Provider Secondary Identifier	O	4			Required
LOOP ID - 2330H					**1**	**N2/3250L**	
3250	NM1	Other Payer Referring Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Referring Provider Secondary Identification	O	3			Required
LOOP ID - 2330I					**1**	**N2/3250L**	
3250	NM1	Other Payer Billing Provider	O	1		N2/3250	Situational
3550	REF	Other Payer Billing Provider Secondary Identifier	O	2			Required
LOOP ID - 2400					**999**	**N2/3650L**	
3650	LX	Service Line Number	O	1		N2/3650	Required
3750	SV2	Institutional Service Line	O	1			Required
4200	PWK	Line Supplemental Information	O	10			Situational
4550	DTP	Date - Service Date	O	1			Situational
4700	REF	Line Item Control Number	O	1			Situational
4700	REF	Repriced Line Item Reference Number	O	1			Situational
4700	REF	Adjusted Repriced Line Item Reference Number	O	1			Situational
4750	AMT	Service Tax Amount	O	1			Situational
4750	AMT	Facility Tax Amount	O	1			Situational
4850	NTE	Third Party Organization Notes	O	1			Situational
4920	HCP	Line Pricing/Repricing Information	O	1			Situational
LOOP ID - 2410					**1**	**N2/4930L**	
4930	LIN	Drug Identification	O	1		N2/4930	Situational
4940	CTP	Drug Quantity	O	1			Required

4950	REF	Prescription or Compound Drug Association Number	O	1			Situational
LOOP ID - 2420A					**1**	**N2/5000L**	
5000	NM1	Operating Physician Name	O	1		N2/5000	Situational
5250	REF	Operating Physician Secondary Identification	O	20			Situational
LOOP ID - 2420B					**1**	**N2/5000L**	
5000	NM1	Other Operating Physician Name	O	1		N2/5000	Situational
5250	REF	Other Operating Physician Secondary Identification	O	20			Situational
LOOP ID - 2420C					**1**	**N2/5000L**	
5000	NM1	Rendering Provider Name	O	1		N2/5000	Situational
5250	REF	Rendering Provider Secondary Identification	O	20			Situational
LOOP ID - 2420D					**1**	**N2/5000L**	
5000	NM1	Referring Provider Name	O	1		N2/5000	Situational
5250	REF	Referring Provider Secondary Identification	O	20			Situational
LOOP ID - 2430					**15**	**N2/5400L**	
5400	SVD	Line Adjudication Information	O	1		N2/5400	Situational
5450	CAS	Line Adjustment	O	5			Situational
5500	DTP	Line Check or Remittance Date	O	1			Required
5505	AMT	Remaining Patient Liability	O	1			Situational
5550	SE	Transaction Set Trailer	M	1			Required

Not Defined:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
	GE	Functional Group Trailer	M	1			Required
	IEA	Interchange Control Trailer	M	1			Required

ISA Interchange Control Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 16

User Option (Usage): Required
Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
ISA01	I01	**Authorization Information Qualifier** **Description:** Code identifying the type of information in the Authorization Information **TennCare Notes:** *Preferred value is '00'*	M	ID	2/2	Required
ISA03	I03	**Security Information Qualifier** **Description:** Code identifying the type of information in the Security Information **TennCare Notes:** *Preferred value is '00'*	M	ID	2/2	Required
ISA05	I05	**Interchange ID Qualifier** **Description:** Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified **TennCare Notes:** *Preferred value is 'ZZ'*	M	ID	2/2	Required
ISA06	I06	**Interchange Sender ID** **Description:** Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element **TennCare Notes:** *This value will be the Sender Trading Partner ID for Inbound Transactions. It will be TennCare's ID '626001445TC' for Outbound Transactions.*	M	AN	15/15	Required
ISA07	I05	**Interchange ID Qualifier** **Description:** Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified **TennCare Notes:** *Preferred value is 'ZZ'*	M	ID	2/2	Required

Code Name

Code	Name
00	No Authorization Information Present (No Meaningful Information in I02)
03	Additional Data Identification

Code Name

Code	Name
01	Duns (Dun & Bradstreet)
14	Duns Plus Suffix
20	Health Industry Number (HIN)
27	Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)
28	Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)
29	Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)
30	U.S. Federal Tax Identification Number
33	National Association of Insurance Commissioners Company Code (NAIC)
ZZ	Mutually Defined

Code	Name
01	Duns (Dun & Bradstreet)
14	Duns Plus Suffix
20	Health Industry Number (HIN)
27	Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)
28	Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)
29	Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)
30	U.S. Federal Tax Identification Number
33	National Association of Insurance Commissioners Company Code (NAIC)
ZZ	Mutually Defined

ISA08	I07	**Interchange Receiver ID** **Description:** Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them **TennCare Notes:** *It will be TennCare's ID '626001445TC' for Inbound Transactions. This value will be the Sender Trading Partner ID for Outbound Transactions.*	M	AN	15/15	Required
ISA09	I08	**Interchange Date** **Description:** Date of the interchange **TennCare Notes:** *Adjudication Date should be plugged. Only one adjudication data per file is allowed.*	M	DT	6/6	Required
ISA13	I12	**Interchange Control Number** **Description:** A control number assigned by the interchange sender **TennCare Notes:** *System generated*	M	N0	9/9	Required
ISA15	I14	**Interchange Usage Indicator** **Description:** Code indicating whether data enclosed by this interchange envelope is test, production or information **TennCare Notes:** *Use 'T' for Test Transactions and ' P' for Production Transactions.*	M	ID	1/1	Required

Code	Name
P	Production Data
T	Test Data

GS Functional Group Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 8

User Option (Usage): Required
Purpose: To indicate the beginning of a functional group and to provide control information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
GS01	479	**Functional Identifier Code** **Description:** Code identifying a group of application related transaction sets **TennCare Notes:** *Same as ISA06* **Code** **Name** HC Health Care Claim (837)	M	ID	2/2	Required
GS03	124	**Application Receiver's Code** **Description:** Code identifying party receiving transmission; codes agreed to by trading partners **TennCare Notes:** *Same as ISA08*	M	AN	2/15	Required

BHT Beginning of Hierarchical Transaction

Pos: 0100	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 6

User Option (Usage): Required
Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
BHT02	353	**Transaction Set Purpose Code** **Description:** Code identifying purpose of transaction set **TennCare Notes:** *18 is used for replacements of rejected files only. The entire transmission should either be replacements (BHT02 = 18) or originals (BHT02 = 00). Reissues/replacements cannot be mixed and matched with the originals. When a transmission is rejected, the entire transmission should be sent again with an 18 in BHT02.* **Code** **Name** 00 Original 18 Reissue	M	ID	2/2	Required
BHT03	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **TennCare Notes:** *Batch Control #*	O	AN	1/50	Required
BHT06	640	**Transaction Type Code** **Description:** Code specifying the type of transaction **TennCare Notes:** *For Encounter 'RP' should*	O	ID	2/2	Required

be used.

Code	Name
31	Subrogation Demand
CH	Chargeable
RP	Reporting

NM1 Submitter Name

Pos: 0200 **Max: 1**
Heading - Optional
Loop: 1000A **Elements: 7**

User Option (Usage): Required
Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM109	67	**Identification Code** **Description:** Code identifying a party or other code **Encounter Notes:** ***Error Message:*** *TennCare Requires 1000A NM109 to be Same Value as ISA06.* ***Detail:*** *The data value in loop 1000A segment NM109 Identification Code must be the same data value contained in the ISA06 segment.*	X	AN	2/80	Required

PER Submitter EDI Contact Information

Pos: 0450 **Max: 2**
Heading - Optional
Loop: 1000A **Elements: 8**

User Option (Usage): Required
Purpose: To identify a person or office to whom administrative communications should be directed

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PER03	365	**Communication Number Qualifier** **Description:** Code identifying the type of communication number **TennCare Notes:** *TennCare Valid value: 'TE'*	X	ID	2/2	Required

Code	Name
EM	Electronic Mail
FX	Facsimile
TE	Telephone

NM1 Receiver Name

Pos: 0200 **Max: 1**
Heading - Optional
Loop: 1000B **Elements: 5**

User Option (Usage): Required
Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM103	1035	**Name Last or Organization Name** **Description:** Individual last name or organizational name **TennCare Notes:** *'TENNCARE'*	X	AN	1/60	Required

NM109	67	**Identification Code** **Description:** Code identifying a party or other code **TennCare Notes:** *Receiver code same as ISA08 '626001445TC'*	X	AN	2/80	Required

PRV Billing Provider Specialty Information

Pos: 0030 **Max: 1**
Detail - Optional
Loop: 2000A **Elements: 3**

User Option (Usage): Situational
Purpose: To specify the identifying characteristics of a provider

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PRV03	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **TennCare Notes:** *Taxonomy code is required on encounter claims in 2000A when Rendering Provider = Billing/Pay-To Provider and 2310E is not used.*	X	AN	1/50	Required

Encounter Notes:
Error Message: BILLING/PAY-TO PROVIDER MISSING - Loop Required by TennCare (2000A 837I)**.**
Detail: PRV segment in Loop 2000A will be required.

NM1 Billing Provider Name

Pos: 0150 **Max: 1**
Detail - Optional
Loop: 2010AA **Elements: 5**

User Option (Usage): Required
Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM109	67	**Identification Code** **Description:** Code identifying a party or other code **Encounter Notes:** ***Error Message:*** *NPI MUST BE THE BILLING PROVIDER PRIMARY IDENTIFIER.* ***Detail:*** *Excludes denied claims with ARC 107. If the Billing Provider is a HealthCare provider (not atypical), If 2010AA NM108 value is = XX and the 2010AA NM109 value is not 10 digits or does not contain a correct check digit, set edit. An atypical provider is identified by the taxonomy code in 2000/PRV03 where PRV01=BI and is defined as any on the taxonomy listing provided by TennCare in the "TennCare Taxonomy Crosswalk" document. These are defined by TennCare as healthcare providers and non-healthcare providers (the N values are Atypical).*	X	AN	2/80	Situational

N3 Billing Provider Address

Pos: 0250 **Max: 1**
Detail - Optional
Loop: 2010AA **Elements: 2**

User Option (Usage): Required
Purpose: To specify the location of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N301	166	**Address Information**	M	AN	1/55	Required
		Description: Address information **TennCare Notes:** *On an encounter, the correct address will be maintained on the provider's master file.*				

N4 Billing Provider City, State, ZIP Code

Pos: 0300 **Max: 1**
Detail - Optional
Loop: 2010AA **Elements: 5**

User Option (Usage): Required
Purpose: To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N404	26	**Country Code**	X	ID	2/3	Situational
		Description: Code identifying the country **Encounter Notes:** ***Error Message:*** *Country Code N404 Invalid. TennCare Requires Services to be provided in the United States.* ***Detai****l: If the Provider has a country code N404 other than 'US', 'PR', 'VI' , 'GU' , 'MP' , 'AS' (United States /US Territories) set the edit.*				

NM1 Pay-to Address Name

Pos: 0150 **Max: 1**
Detail - Optional
Loop: 2010AB **Elements: 2**

User Option (Usage): Situational
Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	**Entity Identifier Code**	M	ID	2/3	Required
		Description: Code identifying an organizational entity, a physical location, property or an individual **TennCare Notes:** *Pay-to provider can be sent sometimes on TennCare*				

Code	Name
87	Pay-to Provider

N4 Pay-to Address City, State, ZIP Code

Pos: 0300 **Max: 1**
Detail - Optional
Loop: 2010AB **Elements: 5**

User Option (Usage): Required
Purpose: To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N404	26	**Country Code**	X	ID	2/3	Situational
		Description: Code identifying the country **Encounter Notes:** ***Error Message:*** *Country Code N404 Invalid. TennCare Requires Services to be provided in the United States.* ***Detail:*** *If the Provider has a country code N404 other than 'US', 'PR', 'VI' , 'GU' , 'MP' , 'AS' (United States /US Territories) set the edit.*				

N4 Pay-To Plan City/State/Zip Code

Pos: 0300 **Max: 1**
Detail - Optional
Loop: 2010AC **Elements: 5**

User Option (Usage): Required
Purpose: To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N404	26	**Country Code**	X	ID	2/3	Situational
		Description: Code identifying the country **Encounter Notes:** ***Error Message:*** *Country Code N404 Invalid. TennCare Requires Services to be provided in the United States.* ***Detail:*** *If the Provider has a country code N404 other than 'US', 'PR', 'VI' , 'GU' , 'MP' , 'AS' (United States /US Territories) set the edit.*				

SBR Subscriber Information

Pos: 0050 **Max: 1**
Detail - Optional
Loop: 2000B **Elements: 5**

User Option (Usage): Required
Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SBR01	1138	**Payer Responsibility Sequence Number Code**	M	ID	1/1	Required
		Description: Code identifying the insurance carrier's level of responsibility for a payment of a claim **TennCare Notes:** *For encounters 'P' should be used*				

Code	Name

		A Payer Responsibility Four B Payer Responsibility Five C Payer Responsibility Six D Payer Responsibility Seven E Payer Responsibility Eight F Payer Responsibility Nine G Payer Responsibility Ten H Payer Responsibility Eleven P Primary S Secondary T Tertiary U Unknown				
SBR02	1069	**Individual Relationship Code** **Description:** Code indicating the relationship between two individuals or entities **TennCare Notes:** *On encounters, there is no dependent information, so this field is always 18.* **Code** **Name** 18 Self	O	ID	2/2	Situational
SBR03	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **TennCare Notes:** *Subscriber SSN*	O	AN	1/50	Situational
SBR09	1032	**Claim Filing Indicator Code** **Description:** Code identifying type of claim **TennCare Notes:** *'MC' should be used* **Code** **Name** 11 Other Non-Federal Programs 12 Preferred Provider Organization (PPO) 13 Point of Service (POS) 14 Exclusive Provider Organization (EPO) 15 Indemnity Insurance 16 Health Maintenance Organization (HMO) Medicare Risk 17 Dental Maintenance Organization AM Automobile Medical BL Blue Cross/Blue Shield CH Champus CI Commercial Insurance Co. DS Disability FI Federal Employees Program HM Health Maintenance Organization LM Liability Medical MA Medicare Part A MB Medicare Part B MC Medicaid OF Other Federal Program TV Title V VA Veterans Affairs Plan WC Workers' Compensation Health Claim ZZ Mutually Defined	O	ID	1/2	Situational

NM1 Subscriber Name

Pos: 0150	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 8

User Option (Usage): Required
Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM108	66	**Identification Code Qualifier** **Description:** Code designating the system/method of code structure used for Identification Code (67) **TennCare Notes:** *'MI' should be used* **Code** / **Name** II — Standard Unique Health Identifier for each Individual in the United States MI — Member Identification Number	X	ID	1/2	Situational
NM109	67	**Identification Code** **Description:** Code identifying a party or other code **Encounter Notes:** ***Error Message:*** *TennCare requires the Member Identification Number to be a numeric value either 9 or 11 bytes in length with no separators.* ***Detail:*** *2010BA NM109 where NM108= 'MI' (NM109 67 Identification Code) Social Security Number as the Member ID, must be a string of exactly 9 numbers with no separators. RID must be a string of 11.* **TennCare Notes:** *Recipient's SSN*	X	AN	2/80	Situational

NM1 Payer Name

Pos: 0150	Max: 1
Detail - Optional	
Loop: 2010BB	Elements: 5

User Option (Usage): Required
Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM109	67	**Identification Code** **Description:** Code identifying a party or other code **Encounter Notes:** ***Error Message:*** *PAYER NAME IDENTIFICATION NUMBER INVALID - TennCare Required ID Number Is Missing (837I, 2010BC/NM109).* ***Detail:*** *If (837I: 2010BC/NM109 where NM101=PR) != 626001445, then set edit.*	X	AN	2/80	Required

REF Billing Provider Secondary Identification

Pos: 0350	Max: 1
Detail - Optional	
Loop: 2010BB	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	**Reference Identification Qualifier** **Description:** Code qualifying the Reference Identification **Encounter Notes:** ***Error Message:*** *TennCare Does not allow multiple provider identifiers within the same provider loop. If NPI is billed, Medicaid ID is not allowed.* ***Detail:*** *If the claim has a provider loop billed with NPI (NM108=XX) then REF02, where REF01 G2, is not allowed.* **Code** **Name** G2 Provider Commercial Number LU Location Number	M	ID	2/3	Required
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.* ***Detail:*** *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*	X	AN	1/50	Required

Encounter Notes:

Error Message: *TennCare Requires a 7 digit Medicaid ID if no NPI is billed for the provider.*
Detail: *If no NPI is present in (2010AA NM108=XX) then 2010BB REF02 must contain a 7 byte alpha/numeric Medicaid ID with REF01=G2.*

CLM Claim information

Pos: 1300 **Max: 1**
Detail - Optional
Loop: 2300 **Elements: 7**

User Option (Usage): Situational
Purpose: To specify basic data about the claim

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CLM02	782	**Monetary Amount** **Description:** Monetary amount **TennCare Notes:** *Total Billed Amount*	O	R	1/18	Required
CLM05-03	1325	**Claim Frequency Type Code** **Description:** Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type **Encounter Notes:** ***Error Message:*** *CLAIM FREQUENCY CODE 7 IS NOT ALLOWED - Replacement Encounter Claims Are Not Processed By TennCare (2300/CLM05-3).* ***Detail:*** *If 2300/CLM05-3 is equal to "7", then error.*	O	ID	1/1	Required

DTP Statement Dates

Pos: 1350 **Max: 1**
Detail - Optional
Loop: 2300 **Elements: 3**

User Option (Usage): Required
Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP03	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *DATE OF SERVICE CANNOT BE BEFORE DATE OF BIRTH - All services must take place on or after the date of birth (2010CA/DMG02 or 2010BA/DMG02).* ***Detail:*** *Excludes denied claims with ARC 107. Date of service = 2300/DTP03 [837I: 2300/DTP03 (DTP01=434)], date of birth = 2010BA/DMG02 or 2010CA/DMG02. Error if date of birth is after date of service. All services must take place on or after the date of birth.* ***Error Message:*** *HEADER SERVICE DATE MUST BE WITHIN DETAIL SERVICE DATES - The detail level dates if used must be within the range of the header dates.* ***Detail:*** *Excludes denied claims with ARC 107. Check if 2400/DTP03 are within 2300/DTP03. This is a claim level edit. The detail level dates, if used, must be within the range of the header dates. If the claim service date is > the detail service date on the claim, an error will be*	M	AN	1/35	Required

reported. The dates are found in 2300/DTP03 (837I: DTP01=434).

Error Message: *ENCOUNTER DATE OF SERVICE CANNOT BE GREATER THAN MCC RECEIPT DATE (2300/K301).*
Detail: *The edit applies to both dates in the 837I. If any service date (837I: 2300/DTP03 where DTP01=434 or 837I: 2400/DTP03 where DTP01=472) is greater than the MCC Receipt Date (2300/K301), then that service date is in error. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (the first date in the date range) should be used for comparing against the Receipt Date. For example, if the DTP segment looked like "DTP*472*RD8*20060911-20060922" the Service date would be "20060911".*

Error Message: *TennCare Requires The Statement Begin and End Date for Bill Type 89x and 66x Claims to be in the same Calendar Month*
Detail: *Excludes denied claims with ARC 107. IF TOB 89x or 66x (x indicates any number) and statement period spans more than one calendar month – set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434.*

REF Payer Claim Control Number

Pos: 1800	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X	AN	1/50	Required

Encounter Notes:
Error Message: *REQUIRED ORIGINAL REFERENCE NUMBER MISSING - TennCare Requires a Voided Claim (CLM05-3 = 8) To Be Submitted With The Original Claim Number (REF02 when REF01= F8).*
Detail: *If 2300/CLM05-3 = 8 and if no data in 2300/REF02 where REF01=F8, then set edit. If 2300/REF01=F8 segment is missing, set the edit.*
TennCare Notes: *MCC's ICN of the void/replacement encounter.*

K3 File Information

Pos: 1850	Max: 10
Detail - Optional	
Loop: 2300	Elements: 1

User Option (Usage): Situational
Purpose: To transmit a fixed-format record or matrix contents

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
K301	449	**Fixed Format Information** **Description:** Data in fixed format agreed upon by sender and receiver **Encounter Notes:** ***Error Message:*** *ENCOUNTER DATE OF RECEIPT IS MISSING - TennCare Requires A Valid MCC Encounter Receipt Date (2300/K301). Valid format CCYYMMDD.* ***Detail:*** *Edit should be applied to the 2300/K301 only. The edit should verify that the MCC Receipt Date (2300/K301) exists (MUST BE USED) and well formatted (Lexical format CCYYMMDD).*	M	AN	1/80	Required

NTE Billing Note

Pos: 1900	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational
Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NTE01	363	**Note Reference Code** **Description:** Code identifying the functional area or purpose for which the note applies **TennCare Notes:** *Additional Information* **Code** **Name** ADD Additional Information	O	ID	3/3	Required
NTE02	352	**Description** **Description:** A free-form description to clarify the related data elements and their content **Encounter Notes:** ***Error Message:*** *REQUIRED CLAIM SEQUENCE NUMBER MISSING - TennCare sequencer is defined as the first subcomponent (NTE02-1) of the 2300 NTE02 where the NTE01 = ADD.* ***Detail:*** *2300 NTE02 is Required for TennCare. The ONLY allowed NTE01 qualifier is 'ADD'. HIPAA defined standard element of length 80. The edit parses the NTE02 when NTE01 = "ADD", from the beginning of the element until either the segment terminator or the pipe symbol "|" is encountered. If the pipe symbol is encountered, all bytes following it until the segment terminator are the claim note and all bytes prior to the pipe are to be considered the Processing Sequence Identifier. If no pipe is found then the entire contents are considered Processing Sequence Identifier (80 bytes).This*	M	AN	1/80	Required

is a SNIP 1 error. The SNIP 7 errors will set when the NTE02 is missing.

HI Occurrence Span Information

Pos: 2310	**Max: 2**
Detail - Optional	
Loop: 2300	**Elements: 12**

User Option (Usage): Situational
Purpose: To supply information related to the delivery of health care

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required
HI02-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required
HI03-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI (01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required
HI04-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI(01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required

HI05-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI (01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required
HI06-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI (01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required
HI07-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI (01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required
HI08-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI (01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required
HI09-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail****: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI (01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required

HI10-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI (01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required
HI11-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12.* ***Detail:*** *Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI (01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required
HI12-04	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** *Error Message: THE FROM DATE CANNOT BE AFTER THE TO DATE FOR OCCURRENCE SPAN CODES 1-12. Detail: Excludes denied claims with ARC 107. Occurrence span date = HI (01-12)-4 where HI (01-12)-1 = BI. If "FROM" date > "TO" date, then set edit.*	X	AN	1/35	Required

HI Value Information

Pos: 2310 **Max: 2**
Detail - Optional
Loop: 2300 **Elements: 12**

User Option (Usage): Situational
Purpose: To supply information related to the delivery of health care

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HI01-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required

HI01-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*	O	R	1/18	Required
HI02-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required
HI02-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code*	O	R	1/18	Required

		= 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.				
HI03-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required
HI03-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*	O	R	1/18	Required
HI04-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required
HI04-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT*	O	R	1/18	Required

		ALLOW A NEGATIVE QUANTITY. ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*				
HI05-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required
HI05-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*	O	R	1/18	Required

HI06-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required
HI06-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*	O	R	1/18	Required
HI07-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required
HI07-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.*	O	R	1/18	Required

		Error Message: *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*				
HI08-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required
HI08-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*	O	R	1/18	Required
HI09-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT*	M	AN	1/30	Required

		WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO. ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*				
HI09-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*	O	R	1/18	Required
HI10-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required
HI10-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date*	O	R	1/18	Required

		minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.				
HI11-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required
HI11-05	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.* ***Detail:*** *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.* ***Error Message:*** *TOTAL DAYS BILLED INVALID.* ***Detail:*** *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*	O	R	1/18	Required
HI12-02	1271	**Industry Code** **Description:** Code indicating a code from a specific industry code list **Encounter Notes:** ***Error Message:*** *TENNCARE REQUIRES COVERED ACTUAL DAYS TO BE PRESENT WITH TOB 89X, EVEN IF COVERED ACTUAL DAYS IS ZERO.* ***Detail:*** *TOB 89x (x is any valid value) Claim Quantity - 2300 Value Information segment present with value code "80" The value of zero is valid but the segment must be present.*	M	AN	1/30	Required

HI12-05	782	**Monetary Amount**	O	R	1/18	Required

Description: Monetary amount
Encounter Notes:
Error Message: *MONETARY AMOUNT VALUE INVALID – TENNCARE DOES NOT ALLOW A NEGATIVE QUANTITY.*
Detail: *If 2300 HI C022 (01 -12) -5 contains a negative value, reject the claim.*

Error Message: *TOTAL DAYS BILLED INVALID.*
Detail: *Excludes denied claims with ARC 107. IF ((Covered days + non-covered days = (statement to-date minus statement from-date)) THEN do not set the edit, ELSE IF (Covered days + non-covered days = (statement to-date minus statement from-date) + 1 or -1), do not set the edit. If any other condition, then set the edit. Statement period = 2300/DPT03 (to date minus from date) where DTP02=RD8 and DTP01=434. Covered days (where Value Code = 80) + non-covered days (Where Value Code = 81) must equal TO date - FROM date with a variance of 0 or 1. The variance is allowed for facilities that may count the discharge date.*

PRV Attending Provider Specialty Information

Pos: 2550 **Max: 1**
Detail - Optional
Loop: 2310A **Elements: 3**

User Option (Usage): Situational
Purpose: To specify the identifying characteristics of a provider

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PRV03	127	**Reference Identification**	X	AN	1/50	Required

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
TennCare Notes: *Taxonomy Code is requested on encounters*

REF Attending Provider Secondary Identification

Pos: 2710 **Max: 4**
Detail - Optional
Loop: 2310A **Elements: 2**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	**Reference Identification Qualifier**	M	ID	2/3	Required

Description: Code qualifying the Reference Identification
Encounter Notes:
Error Message: *TennCare Does not allow multiple provider identifiers within the same*

provider loop. If NPI is billed, Medicaid ID is not allowed.
Detail: *If the claim has a provider loop billed with NPI (NM108=XX) then REF02, where REF01 G2, is not allowed.*

Code	Name
0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number

REF02	127	**Reference Identification**	X	AN	1/50	Required

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Encounter Notes:
Error Message: *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.*
Detail: *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*

Encounter Notes:

Error Message*: TennCare Requires a 7 digit Medicaid ID if no NPI is billed for the provider.*
Detail: *If no NPI is present in (2310A NM108=XX) then 2310A REF02 must contain a 7 byte alpha/numeric Medicaid ID with REF01=G2.*

REF Operating Physician Secondary Identification

Pos: 2710 **Max: 4**
Detail - Optional
Loop: 2310B **Elements: 2**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF02	127	**Reference Identification**	X	AN	1/50	Required

Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Encounter Notes:
Error Message: *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.*
Detail: *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*

REF Other Operating Physician Secondary Identification

Pos: 2710 **Max: 4**
Detail - Optional
Loop: 2310C **Elements: 2**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.* ***Detail:*** *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*	X	AN	1/50	Required

REF Rendering Provider Secondary Identification

Pos: 2710 **Max: 4**
Detail - Optional
Loop: 2310D **Elements: 2**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	**Reference Identification Qualifier** **Description:** Code qualifying the Reference Identification **Encounter Notes:** ***Error Message:*** *TennCare Does not allow multiple provider identifiers within the same provider loop. If NPI is billed, Medicaid ID is not allowed.* ***Detail:*** *If the claim has a provider loop billed with NPI (NM108=XX) then REF02, where REF01 G2, is not allowed.*	M	ID	2/3	Required
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.* ***Detail:*** *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*	X	AN	1/50	Required

Code	Name
0B	State License Number
1G	Provider UPIN Number
G2	Provider Commercial Number
LU	Location Number

N4 Service Facility Location City/State/ZIP

Pos: 2700 **Max: 1**
Detail - Optional
Loop: 2310E **Elements: 5**

User Option (Usage): Required
Purpose: To specify the geographic place of the named party

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
N404	26	**Country Code** **Description:** Code identifying the country **Encounter Notes:** ***Error Message:*** *Country Code N404 Invalid. TennCare Requires Services to be provided in the United States.* ***Detail:*** *If the Provider has a country code N404 other than 'US', 'PR', 'VI' , 'GU' , 'MP' , 'AS' (United States /US Territories) set the edit.*	X	ID	2/3	Situational

REF Service Facility Secondary Identification

Pos: 2710 **Max: 3**
Detail - Optional
Loop: 2310E **Elements: 2**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.* ***Detail:*** *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*	X	AN	1/50	Required

SBR Other Subscriber Information

Pos: 2900 **Max: 1**
Detail - Optional
Loop: 2320 **Elements: 5**

User Option (Usage): Situational
Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SBR01	1138	**Payer Responsibility Sequence Number Code** **Description:** Code identifying the insurance carrier's level of responsibility for a payment of a claim **TennCare Notes:** *Tenncare valid values: 'P'/ 'S' / 'T'. When more than one payer, the last resort is the MCC.*	M	ID	1/1	Required

Code	Name
A	Payer Responsibility Four
B	Payer Responsibility Five
C	Payer Responsibility Six
D	Payer Responsibility Seven
E	Payer Responsibility Eight
F	Payer Responsibility Nine
G	Payer Responsibility Ten
H	Payer Responsibility Eleven
P	Primary
S	Secondary
T	Tertiary
U	Unknown

SBR03	127	**Reference Identification**	O	AN	1/50	Situational
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **TennCare Notes:** *Recipient SSN.*				

CAS Claim Level Adjustments

Pos: 2950 **Max: 5**
Detail - Optional
Loop: 2320 **Elements: 19**

User Option (Usage): Situational
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CAS01	1033	**Claim Adjustment Group Code**	M	ID	1/2	Required
		Description: Code identifying the general category of payment adjustment **TennCare Notes:** *For Encounters 'CO' should be used.*				

Code	Name
CO	Contractual Obligations
CR	Correction and Reversals
OA	Other adjustments
PI	Payor Initiated Reductions
PR	Patient Responsibility

CAS02	1034	**Claim Adjustment Reason Code**	M	ID	1/5	Required
		Description: Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				

CAS05	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*	X	ID	1/5	Situational
CAS08	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*	X	ID	1/5	Situational
CAS11	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*	X	ID	1/5	Situational
CAS14	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be*	X	ID	1/5	Situational

valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)

CAS17	1034	**Claim Adjustment Reason Code**	X	ID	1/5	Situational

Description: Code identifying the detailed reason the adjustment was made

Encounter Notes:
Error Message: *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.*
Detail: *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*

AMT Coordination of Benefits (COB) Payer Paid Amount

Pos: 3000 **Max: 1**
Detail - Optional
Loop: 2320 **Elements: 2**

User Option (Usage): Situational
Purpose: To indicate the total monetary amount

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
AMT02	782	**Monetary Amount**	M	R	1/18	Required

Description: Monetary amount

Encounter Notes:
Error Message: *Capitated Claim (ARC 24) Not Allowed With Paid Amount Greater Than Zero.*
Detail: *Adjustment Reason Code (ARC) 24 is used by TennCare to indicate a capitated claim and/or detail. Placement of ARC 24 in the header CAS segment indicates that the entire claim is capitated. Capitated claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is capitated – ARC 24 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 24 then the header is capitated and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops).*

Error Message: *Denied Claim (ARC 107) Not Allowed With Paid Amount Greater Than Zero.*
Detail: *Adjustment Reason Code (ARC) 107 is used by TennCare to indicate a denied claim and/or detail. Placement of ARC 107 in the*

header CAS segment indicates that the entire claim is denied. Denied claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is denied – ARC 107 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 107 then the header is denied and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops)

Error Message: *MCC PAID AMOUNT CANNOT BE GREATER THAN MCC ALLOWED AMOUNT*
Detail: *Paid amount = 2320/AMT02 where AMT01=D (Payer Paid Amount). If paid amount > allowed amount, then error.*
TennCare Notes: *MCC header level Paid Amount.*

NM1 Other Payer Name

Pos: 3250 **Max: 1**
Detail - Optional
Loop: 2330B **Elements: 5**

User Option (Usage): Required
Purpose: To supply the full name of an individual or organizational entity

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
NM101	98	**Entity Identifier Code** **Description:** Code identifying an organizational entity, a physical location, property or an individual **TennCare Notes:** *One of the 2320 loops will have MCC information in 2330B loops. Additional 2320 loops might have other payer information in the 2330B loop.* **Code** **Name** PR Payer	M	ID	2/3	Required
NM103	1035	**Name Last or Organization Name** **Description:** Individual last name or organizational name **TennCare Notes:** *MCC Name for MCC payment loop.*	X	AN	1/60	Required
NM109	67	**Identification Code** **Description:** Code identifying a party or other code **TennCare Notes:** *MCC ID for MCC payment loop.*	X	AN	2/80	Required

DTP Claim Check Or Remittance Date

Pos: 3500 **Max: 1**
Detail - Optional
Loop: 2330B **Elements: 3**

User Option (Usage): Situational
Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP03	1251	**Date Time Period**	M	AN	1/35	Required
		Description: Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *CLAIM ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO FROM DATE OF SERVICE.* ***Detail:*** *Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any claim service from date (837I: 2300/DTP03 where DTP01=434) is greater than the MCC Claim Adjudication Date (2330B/DTP where DTP01=573), then the claim is in error. Flag the error at the 2330B DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (FROM Date - the first date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080911".* ***Error Message:*** *CLAIM ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO THROUGH DATE OF SERVICE.* ***Detail:*** *Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any claim service 'through' date (837I: 2300/DTP03 where DTP01=434) is greater than the MCC Claim Adjudication Date (2330B/DTP where DTP01=573), then the claim is in error. Flag the error at the 2330B DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the End date (the last date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080922".*				

REF Other Payer Secondary Identifier

Pos: 3550 **Max: 2**
Detail - Optional
Loop: 2330B **Elements: 2**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF02	127	**Reference Identification**	X	AN	1/50	Required
		Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *REQUIRED ENCOUNTER*				

SEGMENT MISSING - TennCare requires at least one 2330B/REF02 segment with REF01=2U for Encounter Claims.
Detail: *Edit will verify that one REF segment at the 2330B level with a REF01=2U, with the first 3 bytes = MCC, is present to indicate the MCC ID.*

Error Message: *MISSING OR INVALID TPL CARRIER CODE - NOT VALID FOR TENNCARE (Data in 2330B REF02 not on TennCare code list).*
Detail: *TennCare Requires the MCC to use valid Third Party Liability carrier codes when reporting TPL payments. Verify that the value submitted in 2330B/REF02 if REF01=2U is contained on the table. If not, set the edit. Must use TN table of carrier codes as a custom code list.*
TennCare Notes: *'MCC' + MCC number for MCC payment loop or TennCare carrier code for all other loops.*

Encounter Notes:

Error Message: *TennCare Requires an REF02 - OTHER PAYER SECONDARY IDENTIFIER (2U) for each 2330B loop.*
Detail: *REF01=2U and REF02=Secondary Payer Identification Number must be present on every 2330B loop.*

REF Other Payer Claim Control Number

Pos: 3550 **Max: 1**
Detail - Optional
Loop: 2330B **Elements: 2**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *REQUIRED MCC ICN MISSING OR INVALID - 2330B/REF02 Must Contain a Valid Internal Control Number.* ***Detail:*** *Mandatory element for MCC loop. If 2330B/REF02=0's or 9's or blank, If REF01 = F8. This edit should set if the qualifier is F8 and the REF02 is zeros or all nines or if missing. Applies only to the MCC loop, not to Third Party Payer loops. The MCCID identifies the MCC loop as 2330B/REF02 when the 2330B/REF01=2U AND 2330B/REF02 has the first three bytes of MCC. If the 2330B loop does not contain this MCC ID, do not apply the edit to require the ICN.* **TennCare Notes:** *MCC generated ICN of the current encounter for MCC payment loop.*	X	AN	1/50	Required

SV2 Institutional Service Line

Pos: 3750 **Max: 1**
Detail - Optional

Loop: 2400 **Elements: 6**

User Option (Usage): Required
Purpose: To specify the service line item detail for a health care institution

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SV203	782	**Monetary Amount** **Description:** Monetary amount **TennCare Notes:** *Line Level Billed Amount.*	O	R	1/18	Required
SV205	380	**Quantity** **Description:** Numeric value of quantity **Encounter Notes:** ***Error Message:*** *ITEM DAYS MUST EQUAL COVERED DAYS ON CLAIM - For Accommodation Revenue Code 0100 Through 0219, Item Days(2400/SV205) Must Equal Header Covered days(Where value code = 80)* ***Detail:*** *Excludes denied claims with ARC 107. Item Days = 2400/SV205. Covered days = Value Code 80. If the Item Days do not equal to covered days, then it is an error. The edit is limited to Accommodation Revenue codes of 0100-0219 or 1000-1005. All other codes should not set this edit. The edit will set if the sum of the units billed on the claim lines for any of the above revenue codes is not equal to the covered days in the header. If txn has days billed in the HI segments (>0) but have no LX lines with Rev code 0100 - 0219 or 1000-1005, it should set the edit. If txn has Rev codes 0100 - 0219 or 1000-1005 and no HI Value code segment, or count doesn't match, then set the edit. If txn has no Value code HI segment and no Rev code with 0100 - 0219 or 1000-1005, then don't set the edit.* ***Error Message:*** *Item Days Must Equal Total Days.* ***Detail:*** *If Item Days is not equal to Total Days set the edit. If Accommodation Revenue Code SV201= 0100 - 0219 or 1001-1005 the Item Days = 2400/SV205 where SV204=DA, must equal Total days* = value code 2300/HIC022 - 05 (where 2300/HIC022 -02=80 + HIC022 - 02=81). ***Error Message:*** *Service Line Quantity Cannot Be Less Than or Equal to Zero.* ***Detail:*** *If the service line Quantity amount is equal to zero or less than zero, set the edit. 837I (2400 SV205).*	X	R	1/15	Required

DTP Date - Service Date

Pos: 4550 **Max: 1**
Detail - Optional
Loop: 2400 **Elements: 3**

User Option (Usage): Situational
Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP03	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *DETAIL SERVICE DATES MUST BE WITHIN HEADER SERVICE DATE RANGE - Dates 2400/DTP03 Must Be Within Date Range In 2300/DTP03.* ***Detail:*** *Excludes denied claims with ARC 107. Header service (statement) date = 2300/DTP03 where DTP01 = 434, Detail service date = 2400/DTP03 where DTP01 = 472). When the detail service date is same as header dates, no error should be reported.* ***Error Message:*** *ENCOUNTER DATE OF SERVICE CANNOT BE GREATER THAN MCC RECEIPT DATE (2300/K301).* ***Detail:*** *The edit applies to both dates in the 837I. If any service date (837I: 2300/DTP03 where DTP01=434 or 837I: 2400/DTP03 where DTP01=472) is greater than the MCC Receipt Date (2300/K301), then that service date is in error. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (the first date in the date range) should be used for comparing against the Receipt Date. For example, if the DTP segment looked like "DTP*472*RD8*20060911-20060922" the Service date would be "20060911".*	M	AN	1/35	Required

LIN Drug Identification

Pos: 4930 **Max: 1**
Detail - Optional
Loop: 2410 **Elements: 2**

User Option (Usage): Situational
Purpose: To specify basic item identification data

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
LIN02	235	**Product/Service ID Qualifier** **Description:** Code identifying the type/source of the descriptive number used in Product/Service ID (234) **TennCare Notes:** *LIN segment required for all J-codes.* **Code** **Name** N4 National Drug Code in 5-4-2 Format	M	ID	2/2	Required
LIN03	234	**Product/Service ID** **Description:** Identifying number for a product or service **TennCare Notes:** *11 bytes for NDC code.*	M	AN	1/48	Required

Encounter Notes:

Error Message: *NDC MISSING – TENNCARE REQUIRED (2410 LIN) WHEN HCPCS J-CODE IS PRESENT ON SERVICE LINE.*

Detail: *If 2400 SV2-2 or SV1-2 on the service line begins with an alpha J and no 2410 LIN is found on the same service line, set the edit. Exclude inpatient claims on the 837I.*

CTP Drug Quantity

Pos: 4940 **Max: 1**
Detail - Optional
Loop: 2410 **Elements: 2**

User Option (Usage): Required
Purpose: To specify pricing information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CTP04	380	**Quantity** **Description:** Numeric value of quantity **TennCare Notes:** *CTP segment required when LIN is present.*	X	R	1/15	Required
CTP05	C001	**Composite Unit of Measure** **Description:** To identify a composite unit of measure (See Figures Appendix for examples of use) **TennCare Notes:** *CTP segment required when LIN is present.*	X	Comp		Required

Encounter Notes:

Error Message: *2410 CTP SEGMENT MISSING – REQUIRED BY TENNCARE WHEN THE HCPCS J-CODE IS PRESENT.*
Detail: *If a HCPCS J-Code is present in the service line with an NDC (2410 LIN03) the 2410 CTP segment is required on the same service line. Inpatient claims on 837I should be excluded from this edit.*

REF Operating Physician Secondary Identification

Pos: 5250 **Max: 20**
Detail - Optional
Loop: 2420A **Elements: 3**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.* ***Detail:*** *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*	X	AN	1/50	Required

REF Other Operating Physician Secondary Identification

Pos: 5250 **Max: 20**
Detail - Optional
Loop: 2420B **Elements: 3**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage

REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.* ***Detail:*** *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*	X	AN	1/50	Required

REF Rendering Provider Secondary Identification

Pos: 5250 **Max: 20**
Detail - Optional
Loop: 2420C **Elements: 3**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.* ***Detail:*** *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*	X	AN	1/50	Required

REF Referring Provider Secondary Identification

Pos: 5250 **Max: 20**
Detail - Optional
Loop: 2420D **Elements: 3**

User Option (Usage): Situational
Purpose: To specify identifying information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF02	127	**Reference Identification** **Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **Encounter Notes:** ***Error Message:*** *TennCare requires Medicaid Identification Number to be a 7 digit alpha numeric value.* ***Detail:*** *For all primary payer providers if REF01 = G2 then REF02 must be 7 byte alpha/numeric.*	X	AN	1/50	Required

SVD Line Adjudication Information

Pos: 5400	Max: 1
Detail - Optional	
Loop: 2430	Elements: 6

User Option (Usage): Situational
Purpose: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
SVD02	782	**Monetary Amount** **Description:** Monetary amount **Encounter Notes:** ***Error Message:*** *Capitated Claim (ARC 24) Not Allowed With Paid Amount Greater Than Zero* ***Detail:*** *Adjustment Reason Code (ARC) 24 is used by TennCare to indicate a capitated claim and/or detail. Placement of ARC 24 in the header CAS segment indicates that the entire claim is capitated. Capitated claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is capitated – ARC 24 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 24 then the header is capitated and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops).* ***Error Message:*** *Denied Claim (ARC 107) Not Allowed With Paid Amount Greater Than Zero.* ***Detail:*** *Adjustment Reason Code (ARC) 107 is used by TennCare to indicate a denied claim and/or detail. Placement of ARC 107 in the header CAS segment indicates that the entire claim is denied. Denied claims should not have a header or any detail paid amounts other than 0; otherwise, set a Normal edit. If a detail line is denied – ARC 107 in detail level CAS - then the detail line should have a paid amount of 0; otherwise, set Normal edit status. If all details have an ARC 107 then the header is denied and header level rules should apply. IF the 2330B loop REF01 = 2U where REF02 [1-3 bytes] = MCC. (This will eliminate non-MCC TPL loops)* **TennCare Notes:** *MCC line level Paid Amount.*	M	R	1/18	Required
SVD05	380	**Quantity** **Description:** Numeric value of quantity **TennCare Notes:** *-999,999.99<= values >=999,999.99*	O	R	1/15	Required

CAS Line Adjustment

Pos: 5450	Max: 5
Detail - Optional	
Loop: 2430	Elements: 19

User Option (Usage): Situational
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CAS02	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed: 1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*	M	ID	1/5	Required
CAS05	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*	X	ID	1/5	Situational
CAS08	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*	X	ID	1/5	Situational
CAS11	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made	X	ID	1/5	Situational

		Encounter Notes: ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*				
CAS14	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*	X	ID	1/5	Situational
CAS17	1034	**Claim Adjustment Reason Code** **Description:** Code identifying the detailed reason the adjustment was made **Encounter Notes:** ***Error Message:*** *VALUE OF ELEMENT CAS INCORRECT - ARC NOT ALLOWED BY TENNCARE.* ***Detail:*** *All Adjustment Reason Codes must be valid according to national code list or TennCare code list. TennCare Allowed:1. 107 - MCC Denied claim (different use for TennCare) 2. B2 - Reform counting covered service (inactive) 3. B19 - Reform appeal for TennCare (inactive) 4. 63 - Correction to a Prior Claim (inactive)*	X	ID	1/5	Situational

DTP Line Check or Remittance Date

Pos: 5500 **Max: 1**
Detail - Optional
Loop: 2430 **Elements: 3**

User Option (Usage): Required
Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
DTP03	1251	**Date Time Period** **Description:** Expression of a date, a time, or range of dates, times or dates and times **Encounter Notes:** ***Error Message:*** *SERVICE LINE ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO FROM DATE OF*	M	AN	1/35	Required

SERVICE.
Detail: *Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any 'from' service date (837I: 2400/DTP03 where DTP01=472) is greater than the line adjudication date (2430/DTP where DTP01=573), then that date is in error. Flag the error at the 2430 DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the Begin date (FROM-the first date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080911".*

Error Message: *SERVICE LINE ADJUDICATION DATE MUST BE GREATER THAN OR EQUAL TO THROUGH DATE OF SERVICE.*
Detail: *Adjudication Date edits apply only to the MCC loops. Edits do not apply to other payer loops. If any end (FROM) service date (837I: 2400/DTP03 where DTP01=472) is greater than the line adjudication date (2430/DTP where DTP01=573), then that date is in error. Flag the error at the 2430 DTP02. The DTP02 should be inspected and if the DTP02=RD8, then the END date (the last date in the date range) should be used for comparing against the Adjudication Date. For example, if the DTP segment looked like "DTP*472*RD8*20080911-20080922" the Service date would be "20080922".*

Encounter Notes:

Error Message: *REQUIRED MCC ADJUDICATION DATE MISSING - DATE 2430/DTP03 Must Be Submitted (DTP01='573') on every detail line for Tenncare.*
Detail: *Segment 2430B/DTP03 where DTP01=573 is required. This is mandatory for all line items for all transaction types. When the 2430B/DTP segment is missing, edit will set. Applies only to the MCC loop, not to Third Party Payer loops. The MCCID identifies the MCC loop as 2330B/REF02 when the 2330B/REF01=2U AND 2330B/REF02 has the first three bytes of MCC. If the 2330B loop does not contain this MCC ID, do not apply the edit to require MCC date.*

GE Functional Group Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required
Purpose: To indicate the end of a functional group and to provide control information

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
GE02	28	**Group Control Number** **Description:** Assigned number originated and maintained by the sender **TennCare Notes: S**ame as GS06	M	N0	1/9	Required

IEA Interchange Control Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required
Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
IEA02	I12	**Interchange Control Number** **Description:** A control number assigned by the interchange sender **TennCare Notes: S**ame as ISA13	M	N0	9/9	Required